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## Depression and Assisted Dying: Putting the Black Dog to Sleep?

Richard Huxtable

### Introduction: Metaphors, Mor(t)ality and Mental Health

Given the sensitivities understandably associated with both depression and dying (whether assisted or not), particular care is needed when discussing their possible linkages. This, of course, assumes that we are amenable to discussing these phenomena at all, whether alone or in combination. Reluctance to converse about death and dying is well-known, hence the Dying Matters awareness campaign, which launched in 2009 under the slogan “dying matters – let’s talk about it”.<sup>1</sup> There are similar campaigns, with similar aims, aimed at enhancing awareness of mental health.<sup>2</sup> Notably, however, when we do talk of dying or mental (ill-) health, there is a tendency to euphemise. References to the “black dog” of depression might owe a debt to Churchill – who, in turn, was indebted to a childhood nanny and, further back, the Ancient Roman lyric poet Horace.<sup>3</sup> The dying might “pass away” or, more flippantly, either “kick the bucket” or follow Shakespeare in “shuffling off this mortal coil”.<sup>4</sup> Shakespeare also inhabits the fringes of our talk of assisted dying (or euthanasia<sup>5</sup>), at least where non-human animals are concerned, when we refer to a creature being “put to sleep”.<sup>6</sup>

Metaphors like these can be a source of comfort: “A metaphor can be a way of naming something that feels too big, frightening, and/or overwhelming to talk about in everyday language”.<sup>7</sup> But metaphors can also obscure. In this chapter, I suggest that some straight(er)-talk is needed, particularly when we are considering the relationship between depression and assisted dying. Focusing on English law, in the first section I argue that the law has been guilty of obfuscation in its dealings with assisted dying. I examine here those situations in which the “assistant” is not a

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<sup>1</sup> Dying Matters <<http://www.dyingmatters.org/>> accessed 30 July 2015.

<sup>2</sup> Mental Health Foundation, ‘Mental Health Awareness Week (MHAW)’ <<http://www.mentalhealth.org.uk/our-work/mentalhealthawarenessweek/>> accessed 30 July 2015.

<sup>3</sup> Paul Foley, “Black dog as a metaphor for depression: A brief history” <<http://www.blackdoginstitute.org.au/docs/Foley.pdf>> accessed 3 May 2016.

<sup>4</sup> Shakespeare, *Hamlet* III.i.

<sup>5</sup> I will focus primarily on voluntary forms of assisted dying i.e. assisted suicide and voluntary euthanasia.

<sup>6</sup> Cf. Shakespeare, note 4.

<sup>7</sup> Denis Whalen, ‘Meeting your Metaphor: The Use of the Arts and the Imagination with Dying Persons’ in Rebecca C Perry Magniant (ed), *Art Therapy with Older Adults: A Sourcebook* (1st edn, Charles C Thomas 2004).

healthcare professional but instead a family member or friend of the deceased. The law-as-stated prohibits such compassionate (or mercy) killing. However, the law-in-action manages to evade the prohibition, sometimes through questionable references to the assistant's depression, by which means a charge of murder is reduced to one of manslaughter by virtue of diminished responsibility.

The dishonesty of such manipulation might strengthen the case for re-stating the law on assisted dying. Some argue that medically-assisted dying should no longer be prohibited in England. However, as I explore in the second section, we also need straight-talking about this specific phenomenon. Some of those jurisdictions that have legalised physician assistance-in-dying have seen the policy extend to include requests from those whose suffering is borne of mental, rather than physical, causes. Such experiences indicate the need for careful discussion, perhaps even before *any* permissive policy is launched, about the rightful limits of such a policy and whether it could – or should – extend to the depressed.

### **At Breaking Point? Depression and Compassionate Killing**

English law as it pertains to assistance in dying is something of a mess – a patchwork of prohibition, permission, and quiet clemency.<sup>8</sup> This patchwork does, however, mean that the warring factions who argue for or against allowing the practice have been stitched together, and relatively stably so. The basic legal framework governing end-of-life decisions owes much to opponents of assisted dying: the law is more comfortable with fatal omissions than with fatal acts,<sup>9</sup> and it is happier to condone the foreseen, rather than the intentional, ending of life.<sup>10</sup> Crucially, English law prohibits assistance in dying, whether or not this is undertaken by a medical professional. As such, assistance in dying will amount to either murder or complicity in suicide, depending on the nature of the assistance offered. Strictly-speaking, a convicted assistant will therefore face either the mandatory life sentence or a maximum prison term of 14 years, respectively. Yet, proponents of assisted dying might take comfort from the lenient ways in which

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<sup>8</sup> Here, I initially revisit some arguments first aired in: Richard Huxtable, *Euthanasia, Ethics and the Law: From Conflict to Compromise* (Routledge 2007).

<sup>9</sup> *Airedale NHS Trust v Bland* [1993] 2 WLR 316.

<sup>10</sup> *R v Adams* [1957] Crim LR 365.

the law operates in practice.<sup>11</sup> The law as it is applied, as opposed to how it is stated, tends therefore to convey something of a compromise.<sup>12</sup>

If we focus on compassionate killing, the main manoeuvre employed to avoid the strictures of the prohibition invites us not to focus on the depressed *victim* (to use the criminal law's terms), but instead on the allegedly depressed *defendant*. Although official statistics are sparse, media reports reveal that the overwhelming majority of those investigated for, or charged with, murder have ultimately been convicted of voluntary manslaughter by virtue of diminished responsibility. Nowadays, for such a plea to succeed, the defendant must satisfy the terms of section 52 of the Coroners and Justice Act 2009, which took effect from 4 October 2010, replacing section 2 of the Homicide Act 1957. The new provision states that a murder conviction will be avoided if the defendant "was suffering from an abnormality of mental functioning" which: "arose from a recognised medical condition"; "substantially impaired" his ability to understand the nature of his conduct, "form a rational judgment" and/or "exercise self-control"; and "provides an explanation" for his conduct, in that it caused him to act as he did.<sup>13</sup> The original wording had offered this partial defence to murder to those "suffering from such abnormality of mind (whether arising from a condition of arrested development or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts or omissions".<sup>14</sup>

To see how this provision has been (mis?)applied to compassionate killers, we should focus first on the original wording. Commentators noted its immediate deployment in cases of this kind,<sup>15</sup> and the trend continued for decades.<sup>16</sup> Perhaps there is nothing untoward in this: the wording, which was "vague and woolly",<sup>17</sup> might easily have encompassed these cases. As such, a compassionate killer might well have had an "abnormality of mind", "if there is medical evidence of, for example, reactive depression".<sup>18</sup> Lawton LJ had suspected the presence of such depression in "nearly all genuine cases of this kind".<sup>19</sup> In her 1980s study of 253 defendants, Dell encountered

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<sup>11</sup> And, in time, they may well get more: see *R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) v The Director of Public Prosecutions* [2014] UKSC 38, where two of the nine Law Lords and Ladies appeared inclined in principle to strike down the prohibition, on human rights grounds.

<sup>12</sup> Huxtable, note 8.

<sup>13</sup> Coroners and Justice Act 2009, s 52.

<sup>14</sup> Homicide Act 1957, s 2(1).

<sup>15</sup> E.g. Barbara Wootton, 'Diminished responsibility: A layman's view' [1960] 76 LQR 224, 229.

<sup>16</sup> E.g. Home Office statistics for 1982-1991: House of Lords Select Committee, *Select Committee on Medical Ethics* (Volume II – Oral Evidence, HMSO 1994) 18.

<sup>17</sup> Lord Justice Lawton 'Do we need a new offence of "mercy killing"? Mercy killing: the judicial dilemma' (1979) 72 JRSM 460.

<sup>18</sup> Criminal Law Revision Committee, *Fourteenth Report: Offences against the Person* (Cmnd 7844, HMSO 1980) 31.

<sup>19</sup> Lawton, note 17, 460-461.

10 compassionate killers, including men who “had reached breaking point under the severe strain of looking after wives with severe mental or physical illnesses”.<sup>20</sup> Subsequent cases depict other compassionate killers who had reached the same point.<sup>21</sup>

But a closer look at the cases reveals that all was not as appeared. Rather, the deployment of diminished responsibility appears to have been a (legal) fiction, designed to signal disapproval, whilst affording compassionate killers the means by which to avoid the mandatory life sentence. Extending the defence to compassionate killers appeared to be out-of-step with Parliament’s intention, which, according to Meakin, was to limit the defence “to states of mind recognised as pathological by psychiatrists or neurologists”.<sup>22</sup> Reactive depression might therefore have been of insufficient severity. The courts nevertheless thereafter more openly embraced this “abnormality of mind”.<sup>23</sup> But we might then doubt whether even reactive depression had been present at the time of the killing. Dell noted that diagnosis could only occur *after* the killing, so perhaps the depression had been triggered by, rather than a trigger for, that occurrence.<sup>24</sup> Even more significantly, she found roughly one third of the compassionate killers she interviewed to be mentally “normal” at the time of diagnosis, with the doctors having *inferred* abnormality at the time of the killing.<sup>25</sup> Perhaps the psychiatrists will have been influenced by their knowledge of the circumstances of the offence.<sup>26</sup> Yet, Dell’s conclusion was stark: compassionate killers appeared to display a “total lack of mental disorder”.<sup>27</sup>

The requirement that the defendant’s “mental responsibility” be “substantially impaired” seemingly fared no better. The phrase – “elliptical almost to the point of nonsense”<sup>28</sup> – appeared to meld ethical and legal, rather than clinical, considerations. Commentators noted that a compassionate killer might well have been entirely “responsible” – he just happened to have viewed “his responsibilities as different from those prescribed by law and acted accordingly”.<sup>29</sup> Nevertheless, the partial defence continued to be applied to compassionate killers and became so

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<sup>20</sup> Susanne Dell, *Murder Into Manslaughter: The Diminished Responsibility Defence in Practice* (OUP 1984) 35-36.

<sup>21</sup> Huxtable, note 8.

<sup>22</sup> RG Meakin, ‘Diminished responsibility: Some arguments for a general defence’ (1988) 52 *Journal of Criminal Law* 406, 409.

<sup>23</sup> *R. v John Samuel Seers* (1984) 79 Cr App R 261.

<sup>24</sup> Dell, note 20, 36.

<sup>25</sup> Dell, note 20, 36.

<sup>26</sup> Wootton, note 15, 230.

<sup>27</sup> Susanne Dell, ‘The mandatory sentence and section 2’ (1986) 12 JME 28, 30.

<sup>28</sup> Edward Griew, ‘Reducing murder to manslaughter: Whose job?’ (1986) 12 JME 18, 19.

<sup>29</sup> Roger Leng, ‘Mercy killing and the CLRC’ (1982) 132 NLJ 76, 77.

routine that a primary source of reference for criminal lawyers explicitly mentioned its availability in cases of this kind.<sup>30</sup>

This application of diminished responsibility rested on a “benevolent conspiracy” between the legal officials and expert witnesses.<sup>31</sup> The process would begin with a sympathetic psychiatrist,<sup>32</sup> who would find ways of interpreting (or spinning?) the defendant’s behaviour as evidence of a disordered mind.<sup>33</sup> Cases revealed that juries could not be credited (or criticised) for accepting such pleas.<sup>34</sup> most such pleas were accepted by the trial judges, working in “collusion” with the prosecution and defence teams.<sup>35</sup> The collaborators would overlook the niceties of the statutory formulation, despite knowing – as one judge confessed – “a few short questions would probably topple the evidential house of cards”.<sup>36</sup>

Once the plea was accepted, attention could turn to sentencing. Freed of the mandatory life term, the judge would have discretion, and sentences were uniformly light. Harsh words would be spoken about the “gravity” of the offence, but the penalty would usually be non-custodial (such as probation) or perhaps a suspended prison term.<sup>37</sup> Despite the apparent nature of the partial defence, psychiatric care orders appeared rare.<sup>38</sup> Perhaps these lenient disposals were entirely appropriate: factors like the unlikelihood of re-offending can mitigate sentences, and these were probably present in many cases of compassionate killing. But aggravating factors will also have been detectable, such as the frailty of the victim and their dependency on the defendant. The judges would try to justify their clemency by emphasising how “unique” or “exceptional” the case was.<sup>39</sup> Such killings were arguably exceptional, at least as compared with non-compassionate killings. But they were not strictly unique: compassionate killings appeared to occupy a distinctive group, which uniformly resulted in the special treatment outlined here.

The law has, of course, moved on, and research is needed to establish whether the old trends persevere. Recent searches yield few reported prosecutions since the 2010 re-formulation, so it is

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<sup>30</sup> Peter Murphy (ed), *Blackstone’s Criminal Practice 2007* (OUP 2007) 157. See further e.g. David Ormerod (ed), *Blackstone’s Criminal Practice 2012* (OUP 2012) 186.

<sup>31</sup> Ronni Mackay, ‘The Coroners and Justice Act 2009 – Partial Defences to Murder: (2) The New Diminished Responsibility Plea’ [2010] Crim LR 290, 294.

<sup>32</sup> Robert Blugrass, *Psychiatry, the Law and the Offender: Present Dilemmas and Future Prospects* (Institute for the Study and Treatment of Delinquency 1980) 9.

<sup>33</sup> House of Lord Select Committee, *Report of the Select Committee on Murder and Life Imprisonment* (HL 78 I-III, HMSO 1989) 676-678.

<sup>34</sup> Huxtable, note 8.

<sup>35</sup> E.g. Lawton, note 17, 461; Blugrass, note 32, 11; Griew, note 28, 79.

<sup>36</sup> Lawton, note 17, 461.

<sup>37</sup> Huxtable, note 8. 32-54

<sup>38</sup> *Ibid.*

<sup>39</sup> *Ibid.*

presently difficult to tell. Perhaps, as Dargue presumes, the old traditions will endure.<sup>40</sup> Certainly, some essential features remain in the new wording: “mental abnormality” becomes “an abnormality of mental functioning”, and the ability to “form a rational judgment” resembles the notion of “responsibility”, which must again be “substantially impaired”.

Yet, Mackay wonders whether the requirement that the abnormality “arose from a recognised medical condition” might now exclude many cases of compassionate killing.<sup>41</sup> One recent case where the plea succeeded, *Webb*, suggests the courts might be taking a stricter line.<sup>42</sup> Some of the old trends re-appear: this was “a tragic case”,<sup>43</sup> which again was “unique”,<sup>44</sup> and the defendant – who had killed his wife at her request – was ultimately issued with a suspended sentence, along with a supervision order and the requirement to co-operate in any treatment or counselling offered by his GP.<sup>45</sup> However, this sentence was notably only passed down on appeal: the trial judge had initially imposed two years’ imprisonment. Furthermore, the psychiatric evidence appeared more substantial than in many of the preceding cases: the defendant was diagnosed with an adjustment order, which “tallied with a medical history of long-term depressive symptoms and significant weight loss”.<sup>46</sup> Perhaps these “two distinguished psychiatrists” once more managed to spin the evidence, and thereafter the court, towards clemency.<sup>47</sup> But perhaps this trial reveals that a slightly harder line is now being taken.<sup>48</sup>

Opinions will vary about whether the courts should continue the subterfuge. Is it fair – to those who are genuinely depressed or to compassionate killers – to depict these killers as depressed and therefore diminished in their responsibility? Do false depictions not risk trivialising the plights of those who are genuinely and seriously depressed? If, as it appears to date, the law is a mess, then there are three broad options for reform: take a (more) *prohibitive* line, take a (more<sup>49</sup>) *permissive* line, or (further) seek to occupy the *middle ground*, for example by reducing the penalties for murder,<sup>50</sup> or by crafting a distinct (lesser) offence of compassionate killing.<sup>51</sup> Any move towards a middle

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<sup>40</sup> Paul Dargue, ‘Mercy killers and the sentencing rules: An uneasy fit?’ (2011) 75 J Crim L 105, 106.

<sup>41</sup> Mackay, note 31, 295.

<sup>42</sup> *R v Webb (George Hugh)* [2011] EWCA Crim 152.

<sup>43</sup> [1].

<sup>44</sup> [17].

<sup>45</sup> [27].

<sup>46</sup> [6].

<sup>47</sup> [15].

<sup>48</sup> Cf. *Inglis* [2011] Crim LR 243.

<sup>49</sup> Cf. *R (on the application of Purdy) v DPP* [2009] UKHL 45; Director of Public Prosecutions, *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* (CPS 2010).

<sup>50</sup> A sentence can already be mitigated if the killing was compassionate: Criminal Justice Act 2003, s 269, sch 21, para 11(f).

<sup>51</sup> E.g. Huxtable, note 8; Heather Keating and Jo Bridgeman, ‘Compassionate Killings: The Case for a Partial Defence’ [2012] 75 MLR 697.

ground offence or, more radically, towards legalisation or decriminalisation would, of course, require the formulation of eligibility criteria, which would necessitate reference not only to the assistant, but also to the assisted. As we will see, proposals to legalise or decriminalise medically-assisted dying tend to focus upon suffering that is borne of some physical – and usually terminal – condition. The arguments have moved on to psychiatric (and other) suffering in some jurisdictions, but English law has appeared uncomfortable with cases in which the suffering endured by the victim appears to have been primarily mental in nature.<sup>52</sup> Whether or not such suffering *should* suffice to reduce or remove criminality will be the focus of the next section, in which we turn from compassionate killing to medically-assisted dying.

### **Dignified or Dangerous? Depression and Medically-Assisted Dying**

The arguments for and against medically-assisted dying have been well aired.<sup>53</sup> Proponents primarily advance two clusters of arguments, the first premised on respect for autonomy (or, more amorphously, the dignity of the patient), the second tethered to the obligation to remove suffering. Sometimes, in what I term the *bare choice argument*, the former claim dominates; elsewhere, the claims are conjoined to form the *understandable choice argument*.<sup>54</sup> Opponents claim that assisted dying is contrary to the obligation to protect all human lives equally and/or it should be resisted in view of its effects, including not only on vulnerable people, but also on the medical profession, with whose values assisted dying might be considered incompatible.<sup>55</sup> Scholars and campaigners on each side continue to spar, whether at the macro level, concerning the practice at large, or down at a micro level, regarding the (un)suitability of medically-assisted dying in a particular case or context.

The appropriateness of medically-assisted dying for the depressed is such a contested context. The battles are waged in two locations. In the central theatre, the focus is on those assisted dying laws that appear to deal with paradigmatic cases, i.e. those involving suffering borne of a somatic and usually terminal cause, but which might (rightly or wrongly) ensnare depressed individuals.<sup>56</sup> In this location we confront divided opinions about whether, in fact, the seriously physically ill who are also depressed are being assisted to die and whether, in principle, they should be eligible for

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<sup>52</sup> Huxtable, note 8, 47.

<sup>53</sup> Huxtable, note 8.

<sup>54</sup> Cf. Jurriaan de Haan, 'The ethics of euthanasia: Advocates perspectives' (2002) 16 *Bioethics* 154.

<sup>55</sup> Richard Huxtable, 'Death on Demand: Proper Medical Treatment?' in Sara Fovargue and Alex Mullock (eds), *The Power of 'Proper Medical Treatment': What Role for the Medical Exception?* (Routledge 2015).

<sup>56</sup> Note, however, that mental ill-health might have a somatic origin.



such assistance.<sup>57</sup> On the periphery, meanwhile, depressed individuals are addressed head-on, with disputes focusing upon whether depression, in and of itself, can be a permissible ground for assistance in dying. It is on the latter – increasingly important – periphery I wish to focus.<sup>58</sup>

Permissive policies on medically-assisted dying are gaining ground: Benelux countries have led the way, with various US states and recently Canada following suit. Although the laws in question differ in some respects, few appear – explicitly at least – to encompass depressed individuals.<sup>59</sup> The notable exceptions are the Netherlands, which has the longest history, Belgium and Switzerland. Dutch law allows for assistance in dying on request, where there is (*inter alia*) “enduring and unbearable” suffering.<sup>60</sup> Originally associated with suffering borne of a somatic cause, in the 1994 *Chabot* case, the Dutch Supreme Court permitted the assistance of depressed Mrs Chabot.<sup>61</sup> Additional safeguards were added for such cases, that the patient must have been examined by an independent colleague and that the patient not have refused any “realistic” alternative treatment. Psychiatric patients can therefore avail themselves of assistance in dying, with 42 having done so in 2013.<sup>62</sup> However, a line was subsequently drawn: the 2002 case of Edward Brongersma, involving a patient who was (merely?) “tired of life”, prompted the Dutch Supreme Court to confirm that (formally, at least) anything short of recognised psychiatric suffering will not be tolerated.<sup>63</sup>

For our purposes, the Belgian law is similar to the Dutch and its application to mental suffering is again rare, with 33/100 requests being granted between 2007 and 2011.<sup>64</sup> Unlike these countries – and, indeed, most permissive jurisdictions, in which specific laws and processes govern assistance in dying – the law in Switzerland seems the simplest: assisted suicide is only unlawful if carried out

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<sup>57</sup> E.g. Margaret P Battin et al, ‘Legal physician-assisted dying in Oregon and the Netherlands: Evidence concerning the impact on patients in “vulnerable” groups’ (2007) 33 JME 591; Ilora G Finlay and Rob George, ‘Legal physician-assisted suicide in Oregon and The Netherlands: Evidence concerning the impact on patients in vulnerable groups – another perspective on Oregon’s data’ (2011) 37 JME 171.

<sup>58</sup> These might alternatively be described in terms of whether depression can be an *excluding* or *qualifying* condition for assisted dying: Colin Gavaghan, ‘In word, or sigh, or tear: Depression and end-of-life choices’ in Pamela R Ferguson and Graeme T Laurie (eds), *Inspiring a medico-legal revolution: Essays in honour of Sheila McLean* (Routledge 2015) 232.

<sup>59</sup> This apparent reluctance is borne out in opinion polls e.g. Udo Schuklenk and Suzanne van de Vathorst, ‘Treatment-resistant Major Depressive Disorder and Assisted Dying’ (2015) JME doi:10.1136/medethics-2014-102458; cf. Gavaghan, note 58, 232.

<sup>60</sup> Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, Article 2(1)(b).

<sup>61</sup> John Griffiths, ‘Assisted Suicide in the Netherlands: The Chabot Case’ [1995] 58 MLR 232.

<sup>62</sup> Schuklenk and van de Vathorst, note 59, 3.

<sup>63</sup> Richard Huxtable and Maaïke Möller, “Setting a Principled Boundary”? Euthanasia as a Response to “Life Fatigue” (2007) 21 Bioethics 117.

<sup>64</sup> Reginald Deschepper, Wim Distelmans and Johan Bilsen, ‘Requests for euthanasia/physician-assisted suicide on the basis of mental suffering: Vulnerable patients or vulnerable physicians?’ (2014) 71 JAMA Psychiatry 617.

“for selfish motives”.<sup>65</sup> Case law and guidance issued by the medical profession have, however, generated more detailed rules to guide assisting doctors, and facilitative organisations – like Dignitas and Exit – have their own specific operating principles. Formally,<sup>66</sup> such guidelines appeared to restrict assistance in dying to the terminally ill and autonomous patient, who has considered (and, if appropriate, tried) alternative options for support. Two recent cases, both reaching the European Court of Human Rights, have nevertheless challenged this limitation.

In *Haas*,<sup>67</sup> the applicant had suffered from a serious bipolar affective disorder for two decades. Having twice attempted suicide unaided and been periodically hospitalised, in 2004 he began to seek medical assistance to die. No psychiatrist was willing to prescribe sodium pentobarbital, which Mr Haas considered an infringement of his right to respect for private and family life, under Article 8 of the European Convention on Human Rights, and specifically his right to control the timing and manner of his death. The Swiss Federal Court notably conceded that psychiatric suffering could be a basis for lawful assistance in dying, although a distinction was to be drawn between an autonomous wish to die and one arising from “a psychological disorder which can and must be treated”.<sup>68</sup> Psychiatric examination was therefore required. Mr Haas considered this requirement also to infringe his Article 8 rights. The European Court of Human Rights, however, judged this to be appropriate, in “protecting everybody from hasty decisions and preventing abuse, and, in particular, ensuring that a patient lacking discernment does not obtain a lethal dose of sodium pentobarbital”.<sup>69</sup>

Like *Haas*, *Gross* involved an individual who had attempted suicide (and, again, been hospitalised for psychiatric treatment), although, more like Mr Brongersma in the Netherlands, Ms Gross had no recognised illness.<sup>70</sup> Once more, the State succeeded in Strasbourg, although this time it was required to clarify its guidelines regarding the prescription of a lethal dose of sodium pentobarbital.<sup>71</sup>

The European Court left it to the Swiss authorities to determine the content of the relevant prescription guidelines. Whether or to what extent these *will* encompass or exclude psychiatric suffering (or indeed suffering not amenable to medical diagnosis) remains to be seen.<sup>72</sup> Of

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<sup>65</sup> Swiss Penal Code, Article 115.

<sup>66</sup> See Isra Black, ‘Existential Suffering and the Extent of the Right to Physician-Assisted Suicide in Switzerland’ (2014) 22 Med L Rev 109, 110.

<sup>67</sup> *Haas v. Switzerland* [2011] ECHR 31322/07.

<sup>68</sup> [16].

<sup>69</sup> [56].

<sup>70</sup> *Gross v Switzerland* [2013] ECHR 67810/10.

<sup>71</sup> Cf. *Purdy*, note 49.

<sup>72</sup> Black, note 66, 117.

particular interest here, however, is whether permissive jurisdictions *should* make medically-assisted dying available to depressed individuals.

Schuklenk and van de Vathorst argue that they should.<sup>73</sup> They focus on treatment-resistant major depressive disorder. The provision of assistance in dying in such a situation might seem far removed from our aforementioned paradigm case, in which, for example, the patient is enduring the terminal phase of cancer. But the authors believe that the cases are ethically comparable, arguing that the restriction of assistance in dying to those suffering physically amounts to unjust discrimination against those struggling with psychiatric illnesses. Certainly, the authors acknowledge some differences: prognostication can be particularly difficult and misdiagnosis is possible here, and, unlike the cancer patients, depressed individuals might well survive if they are not assisted to die. However, Schuklenk and van de Vathorst dispute the objections they anticipate, including that successful treatments might be found, that patients should be offered hope, and that it is better to invest in alternatives short of assistance in dying.

Schuklenk and van de Vathorst deploy arguments common amongst advocates. Explicitly grounding their claims in respect for autonomy, they appear inclined towards the *bare choice argument*. However, they occasionally advance an *understandable choice argument*, when powerful quotations from sufferers and psychiatrists are offered to convey the suffering in question – at least, as we saw earlier, so far as language permits – and thus provide support for acceding to requests for assistance.<sup>74</sup> As they recognise, the usual objections can be anticipated.<sup>75</sup> The objection that is scrutinised here alleges that a proposal like this sets us on a slippery slope. Such arguments are themselves admittedly slippery, but they essentially allege that deleterious effects will follow, as a matter of either logic or empirical fact, from taking the suggested step.

Although they might resist the potentially pejorative label, Schuklenk and van de Vathorst's paper itself takes the form of a logical slippery slope argument, as they explicitly direct their opinions at those who support assisted dying for the physically burdened and they purport to derive conclusions consistent with said supporters' ethical commitments.<sup>76</sup> Many of their arguments appear sound. But consistency can take them further, perhaps into uncomfortable places. What this proposal indicates (again<sup>77</sup>) is a more general point about the *bare choice* and *understandable choice* arguments for permitting medically-assisted dying: any boundaries erected to contain the

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<sup>73</sup> Schuklenk and van de Vathorst, note 59.

<sup>74</sup> Schuklenk and van de Vathorst, note 59, 2-3.

<sup>75</sup> They ignore the general objection that life is inviolable (or sacred) and understandably so, because this adds nothing specific about assisting the depressed to die.

<sup>76</sup> Schuklenk and van de Vathorst, note 59, 1.

<sup>77</sup> Huxtable and Möller, note 63.

phenomenon will be incapable in principle – and might even prove incapable in practice – of being overcome. In short, this proposal sheds light on some wider problems, which merit careful thought whenever policies to permit consensual assisted dying are being contemplated.

We start with the *bare choice argument*. Respect for autonomy does the heavy moral lifting here and Schuklenk and van de Vathorst have in mind a particular account of autonomy, which Coggon would describe in terms of an individual's "best desires".<sup>78</sup> Here the individual's choice expresses her values – the choice is relatively stable and is, in some sense, truly her choice. This account understandably tends to underpin laws, and proposals for, permitting assisted dying; allowing fleeting whims or only objectively-acceptable choices set the bar too low and too high, respectively.<sup>79</sup> However, we might query whether a severely depressed individual's choice for assisted dying truly amounts to that individual's "best desire". Schuklenk and van de Vathorst think it can: such an individual's "depressed self to a large extent constitutes her authentic evolved self", implying we might have no reason for objection on this ground.<sup>80</sup>

Yet, if the individual is to have autonomy – is to be permitted to self-rule in line with her best desires (on this account) – then she needs to be *capable* of self-ruling. This requirement is typically cast in terms of "capacity". On the best desire account of autonomy, this would usually involve assessing whether she is functionally capable of making the decision in question.<sup>81</sup> Different philosophers and lawmakers tend to converge on similar features, such as the need to comprehend, retain and weigh information pertinent to the decision and understand its consequences.

There may be a philosophical problem here: if death is non-existence, "epistemologically there is no information about that prospect to be weighed alongside a continued, suffering-filled, existence."<sup>82</sup> There is certainly an empirical challenge. Gavaghan cites studies which indicate that depressed individuals can perform "adequately" and, like Schuklenk and van de Vathorst,<sup>83</sup> he suggests that such individuals' assessments of their situations might be more realistic than those of the non-depressed.<sup>84</sup> The latter authors argue that procedural justice demands a uniform

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<sup>78</sup> John Coggon, 'Varied and principled understandings of autonomy in English law: Justifiable inconsistency or blinkered moralism?' (2007) 15 Health Care Analysis 235.

<sup>79</sup> See further Huxtable, note 8.

<sup>80</sup> Schuklenk and van de Vathorst, note 59, 5.

<sup>81</sup> The assessment is not predicated on the outcome or content of the decision, as that would stray into "ideal desire" territory, whilst the best desire approach is more pluralistic in outlook.

<sup>82</sup> Matthew R Broome and Angharad de Cates, 'Choosing Death in Depression: A Commentary on "Treatment-resistant Major Depressive Disorder and Assisted Dying"' (2015) 41 JME 586, 586. These authors acknowledge that this problem would affect any proposal for assisted dying. It might also affect many more decisions, since one cannot know or be sufficiently informed about every decision.

<sup>83</sup> Schuklenk and van de Vathorst, note 59, 5.

<sup>84</sup> Gavaghan, note 58, 246.

approach be taken to assessing capacity, irrespective of the person's mental health.<sup>85</sup> Yet Gavaghan also recognises that depression can have an impact on every aspect of capacity: for example, pathological pessimism might adversely influence the individual's values.<sup>86</sup> There may be a parallel here with research by Tan and colleagues, which suggested that patients with anorexia nervosa have unstable preferences and that their authentic choices can be difficult to detect.<sup>87</sup>

Some might therefore hesitate to say that the depressed person's best desires are truly *their* best (let alone their *best*) desires. And there is another problem with the bare choice argument: if choice is all that matters, then there is no reason in principle to restrict assisted dying to those enduring treatment-resistant depression. Indeed, what is to count as "treatment-resistant" – that which I must try but which must fail, or that to which I am resistant (patient-resistant depression, if you will) and therefore cannot succeed? The involvement of a medical professional as a gatekeeper might also be construed as an illegitimate interference with liberty. Taking the bare choice argument to its logical conclusion, there is arguably no reason to tether assisted dying to any sort of medical condition – all which is required is that this be the patient's choice.<sup>88</sup>

Similar problems confront the *understandable choice argument*. Here, the argument refers not only to the patient's autonomous choice but also to her suffering, with the references to "treatment-resistant" positioning assisted dying as a necessary last resort for addressing such suffering. But query the necessity: is assistance in dying the *necessary* next step? There is also a familiar tension: must the patient try other means of addressing her suffering, or should her autonomous wishes win out (i.e. entitle her to refuse unwanted interventions)?

Even if that tension can be resolved, we still need to know *when* we have reached the last resort. Recalling the linguistic, diagnostic and conceptual complications afflicting diminished responsibility, Gavaghan and Broome and de Cates appreciate that diagnostic boundaries are especially fuzzy here.<sup>89</sup> Schuklenk and van de Vathorst agree that it can be difficult to draw the line, but they point to similar problems with attempts to restrict assisted dying to the terminally ill.<sup>90</sup> They have a point but – as with the bare choice argument – such fuzziness threatens to open the (flood) gates to all sorts of suffering as a basis for assistance in dying.

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<sup>85</sup> Schuklenk and van de Vathorst, note 59, 4.

<sup>86</sup> Gavaghan, note 58, 245, 247.

<sup>87</sup> E.g. Tony Hope, Jacinta Tan, Anne Stewart and John McMillan, 'Agency, ambivalence and authenticity: The many ways in which anorexia nervosa can affect autonomy' (2013) 9 Int JLC 20.

<sup>88</sup> Huxtable and Möller, note 63.

<sup>89</sup> Gavaghan, note 58; Broome and de Cates, note 82.

<sup>90</sup> Schuklenk and van de Vathorst, note 59, 2, 4

There are other floodgates or slippery slope objections to which we should be alert. Notice the enhanced role played by the second party, the doctor, in the understandable choice argument: here, she must assess not only the individual's capacity, but also her suffering and quality of life. Might negative judgments affirm and worsen social prejudice and thereby place vulnerable individuals at risk?<sup>91</sup> And once assisted dying is available for such individuals, might this inhibit efforts to find other means of addressing their suffering? Schuklenk and van de Vathorst suggest that other options can continue to be explored,<sup>92</sup> but they fail adequately to account for the potential inhibiting effect. Without due attention to such matters, there is the risk that the authors' proposal, if adopted, will undermine their concern with securing justice.

## Conclusion

From the outset we saw the need for care when discussing dying and depression. Language can be a problem in these contexts, as is evident not only in the way that the law currently operates, but also in the way it might develop, at least if proposals like that from Schuklenk and van de Vathorst are adopted. English law's frequent description of the compassionate killer as depressed and thus diminished in her responsibility appears questionable. Of course, legal practice here might be changing – and it might change considerably, if the law books are to be re-written to permit assistance in dying. But such proposals also prompt questions, and especially so if they are to provide this option to depressed individuals.

Linguistic and principled wooliness abounded throughout this analysis, bringing the risk that steps towards allowing assisted dying for the depressed might set us on a slippery slope. Perhaps the very fact that we are even having these discussions today is indicative of a slippery slope. In recent decades, advocates for assisted dying have tended to focus first on voluntary forms thereof and on patients who were enduring somatic suffering. As Doyal has candidly admitted, this may have been for reasons of political expediency, because these seemed to be the arguments most likely to carry favour.<sup>93</sup> The growing number of laws internationally allowing assisted dying on request, particularly for the terminally ill, seem to bear this out. However, the debates – and indeed practices

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<sup>91</sup> Hazel Biggs and Kate Diesfeld, 'Assisted suicide for people with depression: An advocate's perspective' (1995) 2 Med L Int 23.

<sup>92</sup> Schuklenk and van de Vathorst, note 59, 5.

<sup>93</sup> Len Doyal, 'Dignity in dying should include the legalisation of non-voluntary euthanasia' (2006) 1 Clinical Ethics 65.

– have moved on, and they now encompass non-voluntary forms of euthanasia and, as we have seen, patients enduring psychiatric suffering.<sup>94</sup>

In relation to the latter, it may be that contemporary advocates like Schuklenk and van de Vathorst have also begun with what they believe to be the morally easy (or easier) case i.e. treatment-resistant major depressive disorder. As we have seen, however, there is no reason in principle for so restricting their arguments, given the role played by autonomy and/or the fuzziness of an underpinning concept like “suffering”. It would appear that principles, like breaking points, can be stretched. This suggests a wider point about legislating for assisted dying: since principled boundaries will be hard to erect and defend, careful thought is needed – from the point of conception – about *what* is or is not to be tolerated, and *how* the boundaries are to be policed. It remains to be seen whether, in practice, secure boundaries can be erected and defended.

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<sup>94</sup> E.g. Doyal, *ibid*; Bertha Manninen, ‘A case for justified non-voluntary active euthanasia: Exploring the ethics of the Groningen Protocol’ (2006) 32 JME 643.